

Application for Athletic Trainer Temporary Permit

Name: Indicate your full legal name. If your name has changed at any time during your life, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

Full Name (use no initials)

Last Name _____

First Name _____

Middle Name _____

Suffix _____

Maiden Name _____

Credential (s) _____

All other names used

Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the SDBMOE.

Practice Address

☐ Public Access

☐ Mailing

Street _____

City _____ State/Province _____ Zip Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone (e.g. pager or cell phone) _____

Home Address

☐ Public Access

☐ Mailing

Street _____

City _____ State/Province _____ Zip Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone (e.g. pager or cell phone) _____

Applicant Name: _____ Date: _____

Identification: You must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

____/____/____
Date of Birth (mm/dd/yyyy) Birth City Birth State/Province Birth Country

Gender Social Security Number NPI Number Are you a U.S. Citizen? ☐ Yes ☐ No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to <http://www.cms.hhs.gov/NationalProvIdentStand/>.

Education: List all academic programs you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary.

Education

1.

School Name _____

Address _____

City _____ State/Province _____ Postal Code _____

Country _____

Attendance Dates: From _____ To _____

Graduation Date _____ Degree _____

2.

School Name _____

Address _____

City _____ State/Province _____ Postal Code _____

Country _____

Attendance Dates: From _____ To _____

Graduation Date _____ Degree _____

Applicant Name: _____ Date: _____

Examination History: You are responsible for contacting the Board of Certification (BOC) at <http://www.bocatc.org> and having your scores sent directly to this Board.

Have you taken and passed the examination? ☐ Yes ☐ No

If not, when will you take the exam? _____

List your entire professional examination history using the fields below. Attach additional sheets if necessary.

Examination Name (or National Organization)	Most Recent Date taken (Month/Year)	Passed (P)	or Failed (F)	Number of attempts
		<input type="checkbox"/> P	<input type="checkbox"/> F	
		<input type="checkbox"/> P	<input type="checkbox"/> F	
		<input type="checkbox"/> P	<input type="checkbox"/> F	

Are you currently applying for licensure in another state? ☐ Yes ☐ No

Please list each state where you are applying for licensure _____

State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of professional license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have ever been licensed. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

State Licensure – attach additional pages if necessary

1. State/Province:_____ Type_____ License Number_____ Status _____ Issue Date_____
2. State/Province:_____ Type_____ License Number_____ Status _____ Issue Date_____
3. State/Province:_____ Type_____ License Number_____ Status _____ Issue Date_____
4. State/Province:_____ Type_____ License Number_____ Status _____ Issue Date_____
5. State/Province:_____ Type_____ License Number_____ Status _____ Issue Date_____
6. State/Province:_____ Type_____ License Number_____ Status _____ Issue Date_____
7. State/Province:_____ Type_____ License Number_____ Status _____ Issue Date_____
8. State/Province:_____ Type_____ License Number_____ Status _____ Issue Date_____
9. State/Province:_____ Type_____ License Number_____ Status _____ Issue Date_____
10. State/Province:_____ Type_____ License Number_____ Status _____ Issue Date_____

Applicant Name:_____ Date:_____

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Chronology of Activities: List ALL activities (medical, non-medical and postgraduate training) in chronological order. Begin with the graduation from your professional program to the PRESENT date, using **MONTH** and **YEAR**. For any non-working time, you **MUST** state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address. If you worked for an employment staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS Section.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ <input type="checkbox"/> Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation Other _____
2. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ <input type="checkbox"/> Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation Other _____
3. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ <input type="checkbox"/> Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation Other _____

Applicant Name: _____ Date: _____

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Dates: From/To	Practice/Employment
4. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ <input type="checkbox"/> Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation Other _____
5. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ <input type="checkbox"/> Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation Other _____
6. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ <input type="checkbox"/> Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation Other _____

Applicant Name: _____ Date: _____

Name of patient involved: _____

In which state did the action take place? _____ Case number (if applicable) _____

Which court? _____

(If private compromise or settled before initiation of civil action, state here)

Current status of claim: _____

☐ Open (pending) ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Other_____

Amount of judgment or settlement \$ _____ Amount paid on your behalf \$ _____

Month and year of event precipitating claim: _____

Month and year of lawsuit: _____

Insurance carrier at time: _____

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

[illegible]

Applicant Name: _____ Date: _____

Practice Information (if question does not apply mark NA)

1. Please report your local, South Dakota, home address if different from your current home address reported on the Section 2, Page 1.

2. Proposed South Dakota Practice:

Team Physician: _____

Practice Name: _____

Practice Address: _____

Phone: _____ Fax: _____

Primary Specialty: _____ Subspecialty: _____

Specialty/Subspecialty in which care will be provided: _____

3. Specialty/Subspecialty Certification:

Certifying Board	Specialty/Subspecialty	Date Certified	Date Recertified	Exp. Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If not certified, please state your intent for certification and describe the status of your efforts and eligibility, including scheduled date of exam, past failure of written or oral exams, if any.

4. Drug Enforcement Administration Registration:

DEA Number: _____ State: _____ Exp. Date: _____
_____/_____/_____

Approved for all schedules? ☐ Yes ☐ No, please explain:

If you do not maintain a DEA certificate, please explain:

☐ Not applicable to practice.

☐ DEA certificate pending. Date application submitted: ____/____/____

☐ Other: _____

Applicant Name: _____ Date: _____

Required Disclosures:

ANSWER THE FOLLOWING QUESTIONS. For any "YES" responses, please provide a complete, signed and dated explanation.

Have you, your license or an application for license, whether formally or informally, whether voluntarily or involuntarily:

Professional Questions

1	been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, not renewed by, withdrawn or relinquished to any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2	been subject to proceedings or investigations by a licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization to terminate, stipulate, restrict, limit, withdraw condition, reprimand, suspend, revoke, refuse, deny, relinquish, or not renew your professional license?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3	appeared or been requested to appear before any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization concerning any violation by you of any law, rule, or regulation of any state, district, territory or province of the United States, Canada, or other country?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	been subject to proceedings or investigations (for any reason) by any medical facility or professional society, group, or organization to terminate, stipulate, restrict, limit, condition, reprimand, suspend, revoke, refuse, deny, relinquish, withdraw or not renew membership?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5	been notified of a complaint by a medical facility or professional society, group or organization, or any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6	been dishonorably discharged from a branch of the United States military or National Guard?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7	had your membership, participation, clinical privileges, request for privileges or employment terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, withdrawn or relinquished to or not renewed by any peer review committee or organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is there a review pending?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8	been reprimanded, censured or disciplined by, or been subject to a corrective action agreement/plan with any licensing or disciplinary board, agency or committee, health-related entity, governmental agency or organization, peer review organization, professional assistance program, third party payer, clinic, hospital, or medical staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9	had your certificate or participation in any private, federal (i.e. Medicare, Medicaid, etc.), or state health insurance program terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, relinquished, withdrawn or not renewed, or is any investigation or proceeding with respect to any such action presently underway?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10	been charged by complaint, information, indictment, or otherwise, of any felony or misdemeanor, other than a minor traffic violation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11	plead guilty, or plead no contest to, any felony or misdemeanor, other than a minor traffic violation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12	been convicted of, or received a suspended imposition of sentence or suspended sentence of any kind, to a felony or misdemeanor, other than a minor traffic violation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13	been accused of or been disciplined, found liable, guilty, or responsible for sexual impropriety, sexual harassment, disruptive or discriminatory behavior?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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14	been reported to the NPDB (National Practitioners Data Bank) or HIPDB (Healthcare Integrity and Protection Data Bank) for any reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15	had any cases, whether criminal, civil or administrative (of any kind or description), been brought against you or received notice of intent to do so?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16	had a change in your privileges at any hospital, clinic or health related agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17	been contacted by a regulatory or licensing agency or any health related agency or organization that issued you a medical license for any reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For Questions 18 to 24, use Malpractice Liability Claims Information form to explain yes answers			
18	had any judgments been entered against you in a professional liability cases?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19	had any final judgments or malpractice claims paid by you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20	had any final judgments or settlements or malpractice claims been paid on your behalf by another entity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21	had any malpractice challenges pending against you at this time? (Including any pending claims, lawsuits, judgments, and/or settlements.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22	had any liability insurance carrier cancel your coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23	had been denied coverage or been rated at a higher than average risk class for your specialty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24	any specific procedures excluded from your insurance coverage by your carrier?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Health Disclosure Questions			
1	Do you have a physical, mental or emotional condition which would preclude you from performing the essential functions of your practice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2	Have you ever been treated, hospitalized or confined for any Mental Health issue, including but not limited to: acute stress disorder, anxiety or mood disorder, bipolar disorder, major depressive disorder (recurrent or single episode), obsessive-compulsive disorder, alcoholism or alcohol abuse or drug use? (If yes, please provide letter from treating physician along with your explanation).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3	To the best of your knowledge, information or belief, has any person or entity ever reported or suggested to you, or as a result of a self-evaluation, have you concluded that your use of alcohol or drugs has affected your ability to provide appropriate care to patients or to otherwise perform the usual and necessary function of your medical practice without posing a health risk to your patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	Are you currently using illegal drugs or prescription controlled medications in an illegal manner? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5	Have you used illegal drugs within the last year? ("Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal Law." The term does not include, however, the unlawful use of prescription controlled substances.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Applicant Name: _____ Date: _____

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Affidavit and Authorization for Release of Information. Do not detach this section from the application.

Any references to the terms "Users" or "Users of this Application" in this authorization shall include the following entities:

1. The South Dakota State Board of Medical and Osteopathic Examiners together with its board members, staff members, legal counsels, investigators, agents, employees, contractees, and authorized representatives hereinafter collectively referred to as SDBMOE;
2. Any other state or national medical licensing, medical reporting or medical regulatory board;
3. The Federation of State Medical Boards;
4. Any other South Dakota or United States agency in furtherance of and in compliance with SDBMOE's duties and responsibilities under the South Dakota Medical Practices Act and its administrative regulations.

I am the person described herein. I have not engaged in any acts prohibited by the criminal or medical statutes of the State of South Dakota. I am the person named on any diploma or certificate that I have received, I am the lawful holder of said diploma or certificate, and the diploma or certificate was given to me in the regular course of instruction and examination without fraud or misrepresentation.

I declare and affirm under the penalties of perjury that:

This application for licensure, which includes all the information I have provided and the questions I have answered in this application, have been examined by me, and to the best of my knowledge and belief, are in all things true and correct. I state unconditionally and without reservation that I absolutely understand each and every question contained in this application for licensure, and I have answered all of them completely and truthfully. If any user discovers any derogatory information regarding my personal background that was not disclosed when completing this application, the users may immediately cease all processing of this application, and I agree that such non-disclosure shall disqualify me for licensure in South Dakota.

I understand and agree that my submission of this application and actions subsequent thereto, but prior to licensure, shall bear directly upon my qualifications for licensure, and I fully understand that the SDBMOE may consider all such actions in its determination whether to grant licensure. To that end, I agree that any unprofessional or harassing behavior on my part, or on the part of any agent of mine, with the SDBMOE's members or staff shall establish grounds for the immediate cessation of all processing of this application and disqualify me for licensure in South Dakota. A determination regarding derogatory information or of unprofessional or harassing behavior shall be the sole determination of the SDBMOE, and I will not assert that any other entity, judicial, or otherwise, may make such determination. I understand and agree that cessation of processing of this application by the users as a result of the acts of omissions by myself as described in this paragraph shall not require the SDBMOE, to offer me a hearing or any other due process right, or any other statutory or constitutional rights, and that I will not assert that I am entitled to a hearing.

HIPAA AUTHORIZATION:

I am aware of the Health Insurance Portability and Accountability Act of 1996 (hereinafter called HIPAA) and understand the provisions dealing with the privacy of my medical records. With such knowledge and understanding, I agree to the following:

- a. I do hereby authorize the use or disclosure of my health information by the South Dakota Board of Medical & Osteopathic Examiners (SDBMOE), for purposes of licensure in the state of South Dakota.
- b. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and hospitals, and treatment for alcohol and drug abuse.

I further release, discharge and exonerate all third parties or person(s) from any and all claims, damages, and liabilities of any nature, who in good faith and without malice, release the HIPAA information to the SDBMOE.

THIRD PARTIES:

(The following deals with SDBMOE consulting with and receiving information from third parties.)

I authorize SDBMOE to consult with any third person or party who may have information or evidence concerning my professional, ethical, mental and physical qualifications, or any other matter that SDBMOE deems relevant regarding my continuing qualifications for licensure with SDBMOE. These third persons and parties include hospitals, institutions or organizations, my references, physicians, therapists, previous and present employers, past and present business and professional associates, and local, state, federal or foreign governmental agencies and instrumentalities, courts of any jurisdiction, associations, institutions or law enforcement agencies, together with their representatives thereof, who have custody or control of any documents, records, information or evidence that SDBMOE deems relevant to my Application. **I specifically authorize any state, federal or international law enforcement agency to conduct a background investigation and to report the findings thereof to the SDBMOE.**

Applicant Name: _____ Date: _____

I authorize such third persons and parties to unconditionally release to SDBMOE any such information, including documents, records regarding charges or complaints filed against me, formal, or informal, pending or closed, or any other pertinent data or evidence whether favorable or unfavorable that SDBMOE deems relevant to licensure, and to permit the SDBMOE to inspect, receive, and make copies of such documents, records, evidence, and other information for SDBMOE's evaluation of my professional, ethical, mental and physical qualifications that SDBMOE deems relevant to licensure.

I release, discharge and exonerate from any and all claims, damages and liabilities whatsoever such third persons and parties, together with their authorized representatives, who in good faith and without malice, consult with and release to SDBMOE such information, evidence, files or records requested by SDBMOE that SDBMOE deems relevant to licensure.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand this application and have answered all questions contained in this application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the SDBMOE any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the SDBMOE or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the SDBMOE, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the SDBMOE. I will immediately notify the SDBMOE in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to licensure being granted to me by the SDBMOE.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

Applicant's Signature (**must be signed in the presence of notary***)

Applicant's Printed Last Name

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

Date of Signature

Applicant Photograph

Securely Tape or glue in this square
a recent (less than 6 month old)
front-view 2" x 2" passport-type color
photograph of yourself.

***NOTARY**

Dated _____ Signed _____

State of _____ County of _____

SUBSCRIBED AND SWORN TO before me this _____ day of, _____ 20_____.

My commission expires: _____ (NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: _____ Date: _____

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